

Behavioral Health is Essential To Health



Prevention Works



Treatment is Effective



People Recover



Webinar 6: Quality Measurement and Data Collection Special Issues– Part 1 of 2

Presented by the Substance Abuse and
Mental Health Services Administration
August 16, 2016



Speaker

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Truven Health Analytics, an IBM company

Logistics

- Chat function
- Poll questions

Webinar Schedule

- 1: July 12: Introduction and Background – **States and BHCs**
- 2: July 19: State-Reported Measures – **States Only**
- 3: July 26: State-Reported Measures – **States Only**
- 4: August 2: Clinic-Reported Measures – **States and BHCs**
- 5: August 9: Clinic-Reported Measures – **States and BHCs**
- 6: August 16: Special Issues – **States and BHCs**
- 7: August 23: Special Issues – **States and BHCs**
- 8: September 6: Non-Required Measures – **States Only**

All scheduled for Tuesdays 2:00 to 3:30 pm ET

Focus Today

Continuous Quality Improvement (CQI) and the role of data

Sampling for hybrid measures

Age coverage and stratification measure differences

When is someone a BHC consumer

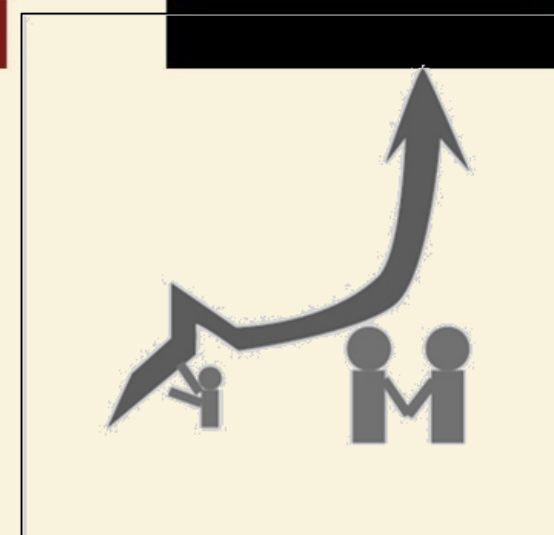
Outstanding questions



Continuous Quality Improvement (CQI) and the Role of Data

CCBHC Criteria and CQI

- **CCBHC Criteria 5.B includes requirements for CQI**
- **Themes include:**
 - *Based on BHC population needs and BHC performance*
 - *Based on data and indicators*
 - *Focuses on improved quality and safety such as suicide prevention*
 - *Demonstrate improvement in performance*
 - *Documented and includes evaluation of CQI activities*
 - *Must include: (1) BHC consumer suicide deaths or suicide attempts; (2) BHC consumer 30 day hospital readmissions for psychiatric or substance use reasons; and (3) other events the state or applicable accreditation bodies may deem appropriate for examination and remediation as part of a CQI plan*



Continuous Quality Improvement (CQI)

HRSA* defines QI as:

“Systematic and continuous actions that lead to measurable improvement in health care services and the health status of targeted patient groups”

and identifies 4 key QI principles:

- 1. Work on the system(s) and its processes**
- 2. Focus on patients**
- 3. Focus on being part of the team**
- 4. Focus on use of the data**

* HRSA, <http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/>

Focus on Use of the Data*

- Separates what is *thought* to be happening from what is *really* happening
- Establishes a baseline (starting with low scores is ok)
- Reduces ineffective solutions
- Allow monitoring of procedural changes
- Indicates whether changes result in improvements
- Allows comparison across sites

* HRSA, <http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/>

CQI and the Quality Measures

- **Quality measures can provide data to help fuel CQI.**
- **For example, the CCBHC criteria (5.b.2) say that consumer 30 day hospital readmissions for psychiatric or substance use problems should be addressed as part of CQI.**
- **Plan All-Cause Readmissions (PCR-BH) provides data that can be useful for this.**

CQI and Data



- For data to be useful as part of CQI, the BHC needs its own CQI, with the state providing feedback on BHC-generated data and the state examining its own data quality.
- When BHCs submit data or measure results to states:
 1. State feedback to BHC regarding data,
 2. State feedback to BHC regarding measure results, and
 3. BHC internal feedback and adjustment regarding both data and results,

all provide grist for ongoing refinement of the system at both the state and BHC level.

Continuous Quality Improvement (CQI)

- **For this to work, you need:**
 - A continuous interdisciplinary team approach to building a robust behavioral health quality measurement system at the state and BHC level
 - Built-in feedback loops focused on improvements in care
 - A process of continuous learning that reinforces positive developments and avoids penalizing
- **Remember the importance of improvement – not just compliance in reporting**

The Big Data Question Is.....



How to get timely feedback so BHCs can improve quickly, especially when the data may not be readily available to the BHC (e.g., pharmacy data or hospitalization or ED data)

- **For the CCBHCs, this will be particularly critical, as it is only a 2 year demonstration program, where it is hoped that there will be improvement from DY1 to DY2**

Beyond the Data

- **Using the data to respond and quickly implement improvement**
 - *Incorporate interdisciplinary teams that include management, providers, those with lived experience (including service recipients), and others involved in all aspects of BHC functioning*
 - *Regularly inform and engage the BHC governing board on results of data analysis and how best to utilize that information to fuel quality improvement*
 - *The BHC will use the CQI data to inform policy and practice*

CQI Resources

- [HealthIT.gov \(2013\). National Learning Consortium. Continuous Quality Improvement \(CQI\) Strategies to Optimize your Practice.](#)
(Click here)
https://www.healthit.gov/sites/default/files/tools/nlc_continuousqualityimprovementprimer.pdf
- [HRSA. Quality Improvement.](#)
(Click here)
<http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/>



Questions?

Sampling for Hybrid Measures

BHC Hybrid Measures That May Utilize Sampling

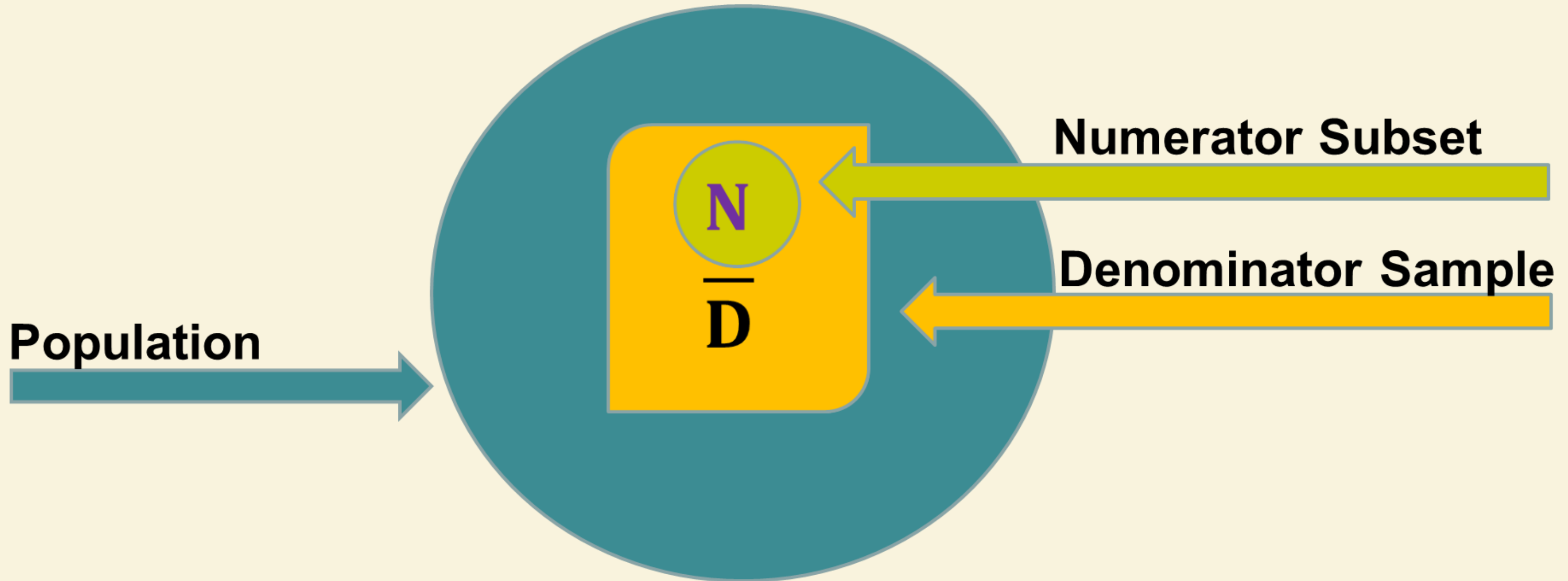
For each of these, you may sample or you may use the entire BHC population

- **Weight Assessment for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents (WCC-BH)** Optional administrative or hybrid, hybrid permits sampling
- **Screening for Clinical Depression and Follow-Up Plan (CDF-BH)** Hybrid
- **Controlling High Blood Pressure (CBP-BH)** Hybrid

The Role of Sampling in Hybrid Measures

- Sampling is most often used when data elements are not easily captured in administrative data. It allows a systematic review of medical records for a representative sample rather than for the entire population.
- The denominator in a hybrid measure may consist of a sample of the eligible population, with the numerator calculated based on that sample, using both administrative and medical records data.

Hybrid Sampling



Sampling Requirements

- **Systematic and random so all have equal chance of inclusion**
- **Representative of the eligible population**
- **If stratified by age, random samples within each age group**
- **Sample size: See next slide**

Sample Size

- **HEDIS requirements: Sample should be 411 unless you have fewer consumers (include all) or “special circumstances” apply. Oversample to allow substitution if some initially thought to be eligible are not.**
- **Appendix C in volume 2 provides additional guidance for using a smaller sample size based on the administrative rate or the past year’s reported rate**

Sample Size -- Appendix C

Appendix C. Guidance for Selecting Sample Sizes for HEDIS® Hybrid Measures

This appendix provides additional information on when it may be feasible to use a sample size of less than 411 when the hybrid method is used. The sample size is based on the current year's administrative rate⁸ or the prior year's reported rate. The guidance in the table below is designed to minimize the burden of medical record review, while providing an adequate sample size for calculating the measure.

Table C.1. Determining Sample Sizes for Hybrid Measures when Data Are Available from the Current Year's Administrative Rate or the Prior Year's Reported Rate

Current Year's Administrative Rate or the Prior Year's Reported Rate	Minimum Sample Size
Less than or equal to 50%	411
51%	411
52%	410
53%	410
54%	409
55%	407
56%	405
57%	403
58%	401
59%	398
60%	395
61%	392
62%	388

- **Current year administrative rate is the current rate calculated using only administrative data**
- **Prior year's reported rate (if there is one)**
- **If either rate was 51% or higher, table C.1 provides appropriate sample size.**
- **If rate was $\geq 95\%$, sample size can be 100.**

Technical Assistance

- **CMS provides technical assistance for the CMS Child or Adult Core Sets for Medicaid/CHIP measures:**

[“Approaches to Using the Hybrid Method to Calculate Measures from the Child and Adult Core Sets” \(October 2014\)](#)

(Click here)

<https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Adult-Health-Care-Quality-Measures.html>

Special Reporting When Using a Sample

- **The Data Reporting Templates for hybrid measures require that you include the sample size and the size of the measure-eligible population in Section B (Data Source).**
- **You also should describe the sampling approach used for each hybrid measure in Section F (Additional Notes).**



Questions?

Poll Question (1)

For BHCs in attendance:

Q1: Does your organization use a certified EHR on the ONC Certified Health IT Product List? (select one of the three answers)

- *Yes*
- *No*
- *Don't know*

Q2: If yes, does your organization attest to Meaningful Use? (select one of the three answers)

- *Yes*
- *No*
- *Don't know*



Age Coverage & Stratification

BHC Measures

Ages and Stratifications

Measure	BHC Measure	
	Age Coverage	Stratification
Routine Care Needs (ROUT)	All ages	
Time to Initial Evaluation (I-EVAL)	12+	12-17 18+ Total
Time to Comprehensive Person and Family-Centered Diagnostic and Treatment Planning Evaluation (TX-EVAL)	12+	12-17 18+ Total
Deaths by Suicide (SUIC)	12+	12-17 18-64 65+
Documentation of Current Medications in the Medical Records (DOC)	18+	
Preventive Care and Screening: Adult Body Mass Index (BMI) Screening and Follow-Up (BMI-SF)	18+	
Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC)	18+	
Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC)	18+	

Measure	BHC Measure	
	Age Coverage	Stratification
Major Depressive Disorder: Suicide Risk Assessment (SRA-A)	18+	
Depression Remission at Twelve Months (DEP-REM-12)	18+	
Housing Status (HOU)	All ages	
Suicide Attempts (SU-A)	12+	12-17 18-64 65+
Patient Experience of Care Survey (PEC)	18+	
Youth/Family Experience of Care Survey (Y/FEC)	≥17	
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (SMI-PC)	18-75	
Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder (AMS-BD)	18+	

BHC/Medicaid Core Measures

Ages and Stratifications

	BHC Measure		Medicaid Adult or Child Core	
Measure	Age Coverage	Stratification	Age Coverage	Stratification
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-BH)	3-17	3-11 12-17	3 to 17	3-11 12-17 Total
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-BH-C)	6-17		6-17	6-17
Screening for Clinical Depression and Follow-Up Plan (CDF-BH)	12+	12-17 18-64 65+	18+	18-64 65+

BHC/HEDIS Measures

Ages and Stratifications

Measure	BHC Measure		HEDIS Measure	
	Age Coverage	Stratification	Age Coverage	Stratification
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	6+		Draft HEDIS 2017	
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)	13+		Draft HEDIS 2017	
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who Are Using Antipsychotic Medications (SSD)	18-64		18-64	
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)	18-64		18-64	
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	1-17	1-5 6-11 12-17 Total	1-17	1-5 6-11 12-17 Total

BHC/Core/HEDIS Measures

Ages and Stratifications

Measure	BHC Measure		Medicaid Adult or Child		HEDIS Measure	
	Age Coverage	Stratification	Age Coverage	Stratification	Age Coverage	Stratification
Controlling High Blood Pressure (CBP-BH)	18-85	18-64 65-85	18-85	18-64, 65-85	18-85	18-85
Plan All-Cause Readmission Rate (PCR-BH)	18+	18-64 65+	18+	18-64, 65+	for medicare use 18+ for commercial use 18-64	
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-BH)	19-64		19-64		19-64	
Follow-Up After Hospitalization for Mental Illness, ages 21+ (adult) (FUH-BH-A)	21+	21-64 65+	21+	21-64 65+	6+ (There is just one HEDIS Measure: Follow-up and Hospitalization for Mental Illness)	
Follow-Up After Hospitalization for Mental Illness, ages 6 to 21 (child/adolescent) (FUH-BH-C)	6-20		6-20	6-20	6+ (There is just one HEDIS Measure: Follow-up and Hospitalization for Mental Illness)	
Follow-up care for children prescribed ADHD medication (ADD-BH)	6-12		6-12		6-12	
Antidepressant Medication Management (AMM-BH)	18+	18-64 65+	18+	18-64 65+	18+	
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-BH)	13+	13-17 18-64 65+	18+	18-64 65+	13+	13-17 18+

When is a Person a BHC Consumer?

Why it Matters

- **When a person is considered a BHC consumer matters for three reasons:**
 - *Are they counted in the quality measure calculation?*
 - *If at a CCBHC, are the services reimbursable under the PPS?*
 - *If at a CCBHC, do the certification criteria apply?*

Established/Existing BHC Clients

- **For purposes of the CCBHCs, become CCBHC consumers upon receipt of the first demonstration service at the CCBHC, once the BHC becomes a CCBHC (when the demonstration begins in that state)**
 - *Includes crisis, telehealth, mobile in-home, services in other settings such as schools or homeless shelters, and any other CCBHC services provided by the CCBHC*
 - *If CCBHC service is received from a DCO before any service is received from the CCBHC directly, is a CCBHC service only if authorized and coordinated by the CCBHC once the BHC becomes a CCBHC*

Non-Established/New BHC Clients (1)

- **For purposes of the CCBHCs, become CCBHC consumers upon receipt of the preliminary screening and risk assessment to determine acuity of needs, with identifying and payment information gathered by the CCBHC**
 - *Includes telehealth, mobile in-home, services in other settings such as schools or homeless shelters, and other CCBHC services provided by the CCBHC including CCBHC-provided crisis services (preliminary screening and risk assessment will be included in the latter service)*

Non-Established/New BHC Clients (1)

- *If state-sanctioned crisis system acting as a DCO for the CCBHC provides crisis services, the person becomes a CCBHC consumer upon receipt of the crisis service AND another of the 9 CCBHC services delivered by the CCBHC*
- *If referred from a hospital or ED, upon preliminary screening and risk assessment to determine acuity of needs, with identifying and payment information, gathered by the CCBHC*



Questions?

Outstanding Questions

Demonstration Year Start Dates

Is there an "official" start date to the demonstration year? We are a little confused about what exact date to use to begin pulling data.

- *Each state establishes its DY start date. It may begin as early as January 1, 2017 or as late as July 1, 2017.*

Accessing Part D Medication Data

To stratify for the dually eligible on measures such as Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-BH), we will need access to Part D medication data and we may not be able to access it.

- [CMS Guide to Requests for Medicare Part D Prescription Drug Event \(PDE\) Data](#)

(Click here)

<https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/GuidePartDv3-3-17-09-2.pdf>

Payer Stratification – “Other”

Does the “other” category include the uninsured?

- *The “other” category does include the uninsured, as well as anyone who does not fall into the: (1) Medicaid only or (2) dually eligible Medicare and Medicaid beneficiary categories. In addition to the uninsured, other examples of individuals in this category might include the commercially insured, those with only Medicare, or those with TRICARE benefits.*

I-EVAL -- Age

For the age ranges when they say 12-17 and 18+, does the individual fall into the 18+ on their birthday and a 17.5 year old in the 17 age bracket?

- *Yes, the person becomes 18+ on their 18th birthday and, on the day prior to that, falls into the 12-17 age bracket.*

Initial Evaluation (I-EVAL) -- Definition

Please define initial evaluation.

- *The measure of time to initial evaluation defines it as follows: “Some certification standards, such as the CCBHC certification criteria, require that an initial evaluation be carried out for new consumers within a specified time frame based on the acuity of needs. In the case of a CCBHC, the initial evaluation is due within 10 business days of first contact for those who present with “routine” non-emergency or non-urgent needs. That standard is used in this specification. Other standards may exist for other entities and this specification can be adapted accordingly.” (I-EVAL specification, p. 31)*
- *The CCBHC certification criteria provide additional information at criteria 2.b.1 (timing) and 4.d.3 (content). This is for purposes of the CCBHC demonstration program and BHCs using this measure that are not CCBHCs may have different standards to meet.*

I-EVAL – Same Day Evaluation

If a consumer calls and is transferred to a clinician and an initial evaluation is done over the phone, does that count as zero days? Similarly, if the consumer calls and asks to come into the office for an evaluation, does that time also count as zero days?

- *As a reminder, the criteria call for a preliminary screening and risk assessment to ascertain level of acuity, followed by an initial evaluation (with timing based on acuity). If a clinician performs the preliminary screening and risk assessment at first contact, the person still needs to receive an initial evaluation within whatever period of time is indicated by their acuity. If they do receive the initial evaluation (which really builds on the preliminary screening) on that call, the initial evaluation was performed in zero days. If a person calls and seeks an appointment, the preliminary screening and risk assessment should be performed on that call. If they come into the office that day and receive an initial evaluation, that is also within zero days. As a further reminder, the criteria encourage the initial evaluation to be performed in person. Criterion 2.b.1 states that, “for those presenting with emergency or urgent needs, the initial evaluation may be conducted telephonically or by telehealth/telemedicine but an in-person evaluation is preferred. If the initial evaluation is conducted telephonically, once the emergency is resolved the consumer must be seen in person at the next subsequent encounter and the initial evaluation reviewed.”*

Tobacco Use: Screening & Cessation Intervention (TSC) – e-Cigarettes

For the measure of screening and intervention for tobacco use, does e-cigarette use fall under tobacco use?

- *The measure includes in the definition of tobacco use “any type of tobacco.” The US Food and Drug Administration regulates e-cigarettes as “deemed tobacco products.” **
 - [A Rule by the Food and Drug Administration on 05/10/2016;](#)
(Click here)
<https://www.federalregister.gov/articles/2016/05/10/2016-10685/deeming-tobacco-products-to-be-subject-to-the-federal-food-drug-and-cosmetic-act-as-amended-by-the> ;
 - [From the FDA Voice "Protecting the Public and Especially Kids from the Dangers of Tobacco Products, Including E-Cigarettes, Cigars and Hookah Tobacco";](#)
(Click here)
<http://blogs.fda.gov/fdavoce/index.php/2016/08/protecting-the-public-and-especially-kids-from-the-dangers-of-tobacco-products-including-e-cigarettes-cigars-and-hookah-tobacco/>
 - [Products, Ingredients & Components](#)
(Click here)
<http://www.fda.gov/TobaccoProducts/Labeling/ProductsIngredientsComponents/default.htm>

Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling (ASC) – AUDIT Alternatives

For the measure of screening and intervention for unhealthy alcohol use, if we have other screens already embedded in our EHR versus the AUDIT, can we use those instead?

- The AUDIT, AUDIT-C, and a single question screen specified in the ASC measure are permissible. Those are the screens you can use to satisfy the numerator. The AUDIT has been validated across gender, age, and cultures. **

* http://apps.who.int/iris/bitstream/10665/67205/1/WHO_MSD_MSB_01.6a.pdf

Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling (ASC) -- AUDIT

Is the AUDIT tool in the public domain?

- The AUDIT was developed by the World Health Organization (WHO) and is available from them as well as other sources. You can access it on the WHO website.

(Click here)

http://apps.who.int/iris/bitstream/10665/67205/1/WHO_MS_D_MSB_01.6a.pdf

- *It also is available from the WHO in Japanese, Spanish and Slovenian.*
- *It is freely available but may not be sold or used for commercial purposes.*

Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling (ASC) -- Timing

For the measure of screening and intervention for unhealthy alcohol use, do the screening and brief intervention need to happen in the same session/encounter?

- *The measure specification does not indicate one way or the other. If you are screening someone for alcohol use, however, the time for a brief intervention is when they are screened. It should happen at the same encounter.*

Tobacco and Alcohol Screening and Intervention (TSC and ASC)

Volume 1 calls this "counseling intervention" whereas Volume 2 calls this "cessation intervention." Is there somewhere where terms are defined?

- *There are two different measures:*
 - **Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC)**
 - **Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling (ASC)**

That is how they are titled in volume one, where the specifications are provided, as well as in volume two, where there are appendices for TSC and ASC.

- *Both measures (and terms) have definitions in volume 1 (TSC on page 67 and ASC on page 70).*

Preventive Care & Screening: Body Mass Index (BMI) Screening & Follow-Up (BMI-SF) – Consumer Based

The measure relates to a BMI during the encounter or within 6 months prior. This appears to be encounter based rather than member based. If a member has multiple encounters during the Measurement Year, are all encounters evaluated?

- *This is a consumer based rather than an encounter based measure.*
 - **The denominator looks at those of the pertinent age who are seen at the BHC at least once in the MY who have at least 1 of the eligible encounters. This looks at data for the MY only to identify the eligible population and is designed to capture those seen during the MY.**
 - **The numerator looks at those, out of the eligible population, who have a documented BMI and, if needed, a follow-up plan. The data used to see if the BMI & follow-up were documented are encounters during the MY, but the BHC can look back 6 months from the encounter to see if BMI was documented earlier (this may take data back into the prior year if the MY encounter is early in the MY). This is only to give the reporter a 6 month grace period in which to have performed the screening. Only 1 BMI screening is counted and that is the most recent.**

Preventive Care & Screening: Body Mass Index (BMI)

Screening & Follow-Up (BMI-SF) – Quit Line

For the measure of screening and cessation intervention for tobacco use, how is cessation intervention defined? What if this person accepts having a phone call with the state quit line?

- *A tobacco cessation intervention “includes brief counseling (3 minutes or less) and/or pharmacotherapy.” To be in the denominator, however, the eligible encounters must be provided by the “provider entity,” which is the BHC. This does not preclude use of a quit line but there should be a brief intervention by the BHC as well.*

Adult BMI/Tobacco Screening -- Documentation

Question: BMI and tobacco cessation screening and intervention are often done as part of a regular office visit with the PCP or mental health professional. Is the requirement that code actually be reported or is another method of documentation--a checkbox, clinical notes--permissible?

• This is a complicated question. The data reporting templates give you the option of indicating that you are using administrative or medical records, with the latter being electronic and/or paper. Yet, for the tobacco screening and adult BMI screening measures, the specifications specifically state that failure to use the quality data codes means the person is excluded from the denominator and the numerator (they are not counted). This is not what SAMHSA wants. The preference is that the codes are used and the process is automated. Failing that, you could use some other form of documentation but you should try to make sure that it is in the EHR and can be captured to allow you to automate the process. You should work towards use of the codes.



Questions?

Preview of Next Two Webinars

Webinar 7: August 23, 2016

Quality Bonus Measures and Payments
Data for the dually eligible population
Lessons learned from state visits
Outstanding questions

Preview of Next Two Webinars

Webinar 8: September 6, 2016

BHC measures not required of CCBHCs as part of demonstration program

BHC Measures (1)

Measure	State or BHC Lead	CCBHC Required	CCBHC Not Required	Webinar
SSD	State	✓	n/a	2
SAA-BH	State	✓	n/a	2
ADD-BH	State	✓	n/a	2
IET-BH	State	✓	n/a	2
PCR-BH	State	✓	n/a	2
FUM	State	✓	n/a	3
FUA	State	✓	n/a	3
FUH-BH-A	State	✓	n/a	3
FUH-BH-C	State	✓	n/a	3
HOU	State	✓	n/a	3
PEC	State	✓	n/a	3
Y/FEC	State	✓	n/a	3

BHC Measures (2)

Measure	State or BHC Lead	CCBHC Required	CCBHC Not Required	Webinar
I-EVAL	BHC	✓	n/a	4
BMI-SF	BHC	✓	n/a	4
TSC	BHC	✓	n/a	4
ASC	BHC	✓	n/a	4
CDF-BH	BHC	✓	n/a	5
WCC-BH	BHC	✓	n/a	5
SRA-BH-C	BHC	✓	n/a	5
SRA-A	BHC	✓	n/a	5
DEP-REM-12	BHC	✓	n/a	5

BHC Measures (3)

Measure	State or BHC Lead	CCBHC Required	CCBHC Not Required	Webinar
ROUT	BHC	n/a	✓	8
TX-EVAL	BHC	n/a	✓	8
SUIC	BHC	n/a	✓	8
DOC	BHC	n/a	✓	8
CBP-BH	BHC	n/a	✓	8
SU-A	State	n/a	✓	8
APM	State	n/a	✓	8
SMC	State	n/a	✓	8
AMS-BD	State	n/a	✓	8

Contact Information

Please submit additional questions to CCBHC_Data_TA@samhsa.hhs.gov about:

- Material covered today
- Material scheduled for the next webinar
- Other questions related to data collection, analysis, or reporting

We will respond to them in the remaining webinars or in writing.

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